

CHAPTER 2: COMMUNITY SERVICES ASSESSMENT

A community services assessment is an essential component of the HIV prevention community planning process. A community services assessment is comprised of three steps:

- 1) *Needs assessment* — The process of obtaining and analyzing information to determine the current status and service needs of a defined population or geographic area.
- 2) *Resource inventory* — Current HIV prevention and related resources and activities in the project area, regardless of the funding source. A comprehensive resource inventory includes information regarding HIV prevention activities within the project area and other education and prevention activities that are likely to contribute to HIV risk reduction.
- 3) *Gap analysis* — A description of the unmet HIV prevention needs within the high-risk populations defined in the epidemiologic profile. The unmet needs are identified by a comparison of the needs assessment and resource inventory.

The goal of the community services assessment is to examine both the met and unmet needs of each priority population selected and identify barriers to reaching them and engaging them in prevention activities. A met need is a required service that is currently being addressed through existing HIV prevention resources that are available to, appropriate for, and accessible to that population as determined through the resource inventory. An unmet need is a required service that is not currently being addressed through existing HIV prevention services and activities, either because no services are currently available or because available services are either inappropriate for, or inaccessible to, the target populations.

Additionally, the assessment of prevention needs furnishes information about the extent to which specific target populations are aware of HIV transmission methods and high-risk behaviors, are engaging in specific high-risk behavior, have been reached by HIV prevention activities, and are likely to participate in HIV prevention activities. The assessment also identifies barriers that make it difficult to reach specific target populations and involve them in HIV prevention initiatives and suggests strategies that may be effective in overcoming these barriers.

Priority Populations

After detailed review of the Epi Profile, the Prevention Committee put forward recommendations at the June 16, 2009 meeting of the SC HIV Planning Council for seven priority populations for the five-year HIV Prevention Plan (2010-2014). Only a slight modification was made from the previous Prevention Plan (2004-2009). The recommendations were ratified by the full Council. The seven priority populations, in rank order, were:

- 1) Persons living with HIV/AIDS
- 2) African American Men who have Sex with Men, Ages 15-44
- 3) African American Women who have Sex with Men, Ages 15-44
- 4) African American Men who have Sex with Women, Ages 15-44
- 5) White Men who have Sex with Men, Ages 15-44

- 6) Injection Drug Users, Ages 20-44
- 7) Hispanics/Latinos.

With the new HIV Prevention Planning Guidance, released in 2012, it is noted that the priority populations do not need to be prioritized in rank order. **Accordingly, the Priority Populations are now listed and not rank-ordered, to include: Persons living with HIV/AIDS, African American Men who have Sex with Men (Ages 15-44), African American Women who have Sex with Men (Ages 15-44), African American Men who have Sex with Women (Ages 15-44), White Men who have Sex with Men (Ages 15-44), Injection Drug Users (Ages 20-44), and Hispanics/Latinos.** Surveillance data for 2012 will be reviewed to determine if any changes need to be made to the priority populations for 2013, including the target ages for each population.

The populations are more fully discussed in Chapter 3: Priority Populations.

1. Needs Assessments of Priority Populations

On a yearly basis, the Prevention Committee reviews the literature and explores any new information on effective behavioral interventions and recommends to the full HIV Planning Council any necessary changes to the priority interventions table in Chapter 3. Since the last HIV Prevention Plan was submitted in 2004 for 2005-2008 (the first years of the SC HIV Planning Council, the integrated planning body for both HIV prevention and care) and the update for 2010-2014, a number of needs assessment activities have been completed or are underway.

In 2005, focus groups were conducted across the state with HIV positive consumers, both in care and out of care. In 2007, a town hall forum with facilitated discussion was held one evening for African American MSM in conjunction with the state HIV/STD Conference and, from January 2008-April 2009, focus groups with this population were also held. In 2008, a town hall forum was similarly held at the HIV/STD Conference with People Living with HIV/AIDS. Also in 2008, a survey was conducted with consumers of Ryan White Part B programs. In 2009, additional focus groups and/or key informant interviews were completed with White MSM and Hispanic/Latino MSM as part of the data collection efforts for the development of the state's MSM Strategic Plan. A survey of Transgender persons was also conducted in 2009 to gather information from this population, which had not been specifically addressed in previous data collection initiatives. These efforts were fully described in the plan originally submitted for 2010-2014, submitted in late 2009, but are included herein as the updated plan for 2010-2014.

2005 Focus Groups with Persons Living with HIV/AIDS

The purpose of this assessment was to identify the prevention and care needs of persons living with HIV/AIDS, to identify what influences HIV positive people to seek and/or continue HIV/AIDS medical care, and the perceived quality of HIV prevention and care services in South Carolina. The project was designed and executed in collaboration with the SC HIV Planning Council, the SC Ryan White Care Consortia, the National Alliance of State and Territorial AIDS Directors (NASTAD), DHEC's STD/HIV Division, and researchers from the Arnold School of Public Health at the University of South Carolina. Discussion guides addressed the following four areas as they impact (or affect) people living with AIDS: service utilization, barriers to care

and unmet needs, prevention services and testing, and consumer involvement. Twenty (20) focus groups were held, with a total of 113 participants across 12 sites. The final report of these findings may be found on the HPC website at

http://www.schpc.org/images/Final_Report_Focus_Groups_with_Consumers_3.6.pdf.

2007 Town Hall Meeting with African American MSM

A Town Hall Meeting for African American Men who have Sex with Men was held on October 17, 2007, sponsored by the SC HIV Planning Council and the AAMSM Workgroup. The survey instrument was a one-page, 10-item, self-administered questionnaire developed by the AAMSM Workgroup. It included questions about demographics, HIV status and testing history, sexual identity, recognition of the “Many Men, Many Voices” HIV prevention intervention, and awareness of/participation in community HIV/AIDS services. There were also two qualitative questions about the services needed for AAMSM in respondents’ respective communities, and AAMSM issues in their communities. The survey was administered at the AAMSM Workgroup’s Information and Awareness Forum at the 2007 South Carolina STD/HIV Conference. Thirty-seven AAMSM responded to the survey. After respondents completed the survey, they participated in a moderated discussion, lasting approximately 45 minutes, in which they were asked additional questions about the perception of HIV in AAMSM communities, HIV/AIDS service delivery, barriers to AAMSM participation in HIV/AIDS programs, and strategies for overcoming those barriers. The Report from the 2007 Town Hall Meeting with AAMSM is available on the HPC website at

http://www.schpc.org/images/Final_Report_from_AAMSM_Workgroup_Forum_held_on_October_17,_2007_-_final_report_1-31-08.pdf.

2008 Consumer Town Hall Forum for People Living with HIV/AIDS

In 2008, the SC HIV Planning Council (HPC), with guidance from its Consumer Advisory Committee and Needs Assessment Committee, elected to pursue the development and implementation of a Consumer Town Hall Forum to access direct input from persons living with HIV/AIDS across South Carolina. Working with the SC HIV/STD Conference Executive and Planning Committees, the HPC made plans to hold the Forum at the conference hotel and conference center one evening during the conference. The Conference’s Scholarship Committee worked closely with the HPC to enhance and support registration and lodging scholarship opportunities for consumers. Utilizing the Conference’s scholarship application process and with additional support from an anonymous donor, forty-five (45) registration scholarships were awarded, with twenty-five (25) of those recipients (who lived more than 50 miles outside of Columbia) also receiving lodging for the two nights of the conference. Additionally, HIV positive consumers not attending the conference were invited through area AIDS Service Organizations (ASOs) and encouraged to attend and participate. A total of sixty-two (62) consumers attended the event, which was held on October 15, 2008. Input from the Consumer Town Hall Forum was utilized both in the development of the Ryan White Statewide Coordinated Statement of Need (SCSN) and Comprehensive Plan, as well as the HIV Prevention Plan for 2010-2014. The final report from the Consumer Town Hall Forum is available on the HPC website at

http://www.schpc.org/images/Consumer_Town_Hall_Forum_Summary_Report_Final_12-08.pdf

January 2008 - April 2009 Focus Groups with African American MSM

Based on the results of an African-American Men who have Sex with Men (AAMSM) Town Hall Forum held at the 2007 South Carolina STD/HIV Conference, a plan was developed to hold a series of focus groups throughout the state. These focus groups and the data analysis were made possible through a collaborative effort between the AAMSM Workgroup, the South Carolina HIV/AIDS Council, Lowcountry AIDS Services, AID Upstate, HopeHealth, and the South Carolina HIV Planning Council. The focus groups were designed to expand upon the findings of the Town Hall Forum, eliciting participants' responses to questions about general AAMSM health issues, HIV risk factors, awareness of and participation in HIV prevention programs, barriers to mobile HIV testing, and strategies for overcoming those barriers.

Initially, six focus groups were held in the first quarter of 2008 at community-based organizations who had received funding to implement the "Many Men, Many Voices" curriculum: the South Carolina HIV/AIDS Council in Columbia; Lowcountry AIDS Services in Charleston; and AID Upstate in Greenville. Additional groups of mixed ages were held at the three initial focus group sites, for a total of twelve focus groups. A total of 88 AAMSM took part in the twelve focus groups. Forty participants were between the ages of 18 and 25, and 48 participants were age 26 or older. There were some participants who came to groups that did not match their age group, due to scheduling conflicts with their age-appropriate group or being recruited to participate in the wrong group. Because their experiences and input were still considered valuable, they were not turned away in those situations. **The final report from the January 2008 - April 2009 Focus Groups with African American MSM may be found on the HPC website at**

http://www.schpc.org/images/2009_08_AAMSM_Focus_Group_Report.pdf.

2008-2009 Hispanic/Latino Community Needs Assessment Activities

On June 4, 2008, a Statewide Hispanic/Latino HIV/AIDS Strategy Roundtable Summit was held in Columbia. One of a series of summits held in the Southeast, the event provided information that was used to develop a set of recommendations identifying needs of the Hispanic/Latino community. Co-sponsored by the Latino Commission on AIDS, the Deep South Project, Palmetto AIDS Life Support Services (PALSS), Catawba Care Coalition, the SC Hispanic/Latino Health Coalition, and the SC DHEC STD/HIV Division, the meeting included introductory remarks, presentation of Hispanic/Latino epidemiologic data, a panel discussion, and smaller workgroup discussions. Recommendations from the event fell into six broad categories: Data and Research, Outreach and Recruitment, Culturally and Linguistically Appropriate Services, Networking, Intervention, and Policy. These recommendations were accepted by the HPC at its August 19, 2008 meeting:

Cultural and Linguistic Competency Recommendations:

- Help agencies recruit and retain bilingual staff.
- Find out where to get Spanish-language materials.
- Increase consumers' understanding of how U.S. medical system works.
- Get all dialects available on the language line (e.g. Mixteco).
- Produce culturally and educationally appropriate materials (no higher than 4th-grade literacy level).
- Encourage services to expand hours to accommodate Latino clients.

Data/Research Recommendations:

- Compile data on what happens when clients come to facilities, i.e. DHEC, RW clinics? What is the reality of service provision?

Intervention Recommendations:

- Learn about the interventions already developed for this population.

Outreach recommendations:

- Forge links with Spanish-language media in the area.
- Identify key people in the community as potential intermediaries (e.g. business owners, trailer parks, apartment complexes).
- Identify and map community resources.
- Build trust in available services.
- Publicize policy that RW is available to undocumented; create a resource directory?

Networking recommendations:

- Create a subcommittee within the state Planning Council.
- Use the PC outreach and training group to build capacity throughout the state.
- Liaison with other communicable diseases' staff.

Policy recommendations:

- Collect data disaggregated by ethnicity (not just white, black, other).
- Increase Latino representation on Planning Council.
- Open Planning Council to ER representatives.
- Formulate recommendations to DHEC on how to improve access.
- Encourage students in the health professions to learn Spanish.

A formal report of the data, beyond these recommendations, is not available. As a direct result of the recommendations from the Roundtable Summit Recommendations, the HPC Hispanic/Latino Workgroup was created.

October 2008 – February 2009 Survey of People Living with HIV/AIDS

The South Carolina Department of Health and Environmental Control (DHEC) contracted with Public Consulting Group (PCG), Inc. to conduct a Needs Assessment of People Living with HIV/AIDS (PLWHA) in order to identify the HIV care and treatment needs of the clients in care throughout the eleven (11) Ryan White Part B HIV/AIDS Service Providers in South Carolina.

PCG conducted surveys on site at all eleven providers in South Carolina which include: ACCESS Network, Inc.; AID Upstate; CARETEAM; Catawba Care Coalition, Inc.; Hope Health Edisto; Hope Health Lower Savannah; Hope Health Pee Dee; Medical University of South Carolina; USC Department of Medicine; Upper Savannah Care Services; and Piedmont Care, Inc. throughout the months of October through December, 2008 and follow up surveys in January and February, 2009. The 11 service providers provide medical care and supportive services to people living with HIV/AIDS, with a focus on the following core services: outpatient/ambulatory medical care, ADAP (local), oral health care, health Insurance premium and cost sharing assistance, home health care, home and community-based health services, hospice services, mental health services, medical nutritional therapy, medical case management, and outpatient substance abuse services.

Additionally, limited support services including case management (nonmedical), emergency financial assistance, food bank/home delivered meals, health education/risk reduction, housing services, legal services, linguistics services, medical transportation services, outreach services, psychosocial support services, referral for health care/supportive services, and treatment adherence counseling are offered to patients in order to allow patients access to care and retention in care. All of the 46 counties in South Carolina are served by one of the 11 service providers depending on geographic proximity to the service provider. ADAP services are available through a direct dispensing model for all eligible patients and insurance assistance for persons with low income HIV/AIDS population throughout the state of South Carolina. PCG's objective was to identify gaps, barriers, and needs in the Ryan White Services that the eleven providers offer to HIV/AIDS clients. The survey was administered to clients who currently receive care or had received care at that specific provider within the past two years. DHEC and PCG determined the number of samples needed for the surveys for each provider.

PCG's final report of the Ryan White Part B Consumer Surveys is data in table format. A summary analysis of the findings, done for the purpose of reporting for this Plan, indicated that 560 randomly selected clients, served by a Ryan White Part B service provider in the past two years, were surveyed. The purpose of the survey was to gain insight into the client's knowledge of available services and whether clients are accessing needed services. This assessment also identified service gaps and those service needs not being met for the clients.

Testing and Linkage

Thirty-four percent of clients found out they were positive by requesting a test. The majority of clients were diagnosed through passive methods: 48% found out when receiving care for something else, 4% found out when donating blood, and 5% found out in prison. 84% report being referred to HIV medical care when they became aware of their HIV status. 70% report going to medical care immediately, 17% went within one year, and 13% waited 1 year or more.

Medical Care

Ninety-eight percent of survey respondents were HIV positive clients receiving medical care. 2% were HIV positive and not receiving care. 91% claimed to not often miss their medical appointments. Of those 9% missing medical appointments, transportation was the most commonly sighted reason. Other reasons included: worried someone will find out status, no way to pay for it, work schedule, and forgetting. 94.4% of respondents with AIDS reported that they take their medications daily, on a regular schedule as prescribed. If clients were to miss doses the top reasons include: forgetting, side effects, difficult schedule, and not wanting to take the medications. 76.9% reported having received HIV/AIDS education and/or counseling.

Satisfaction with Medical Services

Table 1.

	Satisfaction	Dissatisfaction
Contacting Medical Doctor	74% very satisfied	2% very dissatisfied
Doctor's Medical Advice	95% satisfied	5% dissatisfied
Nurse's Medical Advice	87% satisfied	13% dissatisfied
CM Medical Advice	84% satisfied	16% dissatisfied

Knowledge and Use of Available Services

The most commonly reported accessed services were: Medical Care (85% accessed), Medical Case Management (66%), AIDS Drug Assistance (60%), Oral Health Care (48%), Health Education/Risk Reduction (46%), and Medical Transportation (30%). These most commonly used services were also those that most clients knew were available to them. Clients were most aware of available Medical Care (95% known), AIDS Drug Assistance (90%), Psychosocial Support (88%), Medical Case Management (87%), Medical Transportation (86%) and Health Education/Risk Reduction (85%).

The most unknown services to clients were: Health Insurance Assistance (59% unknown), Housing Services (55%), and Legal Services (46%). All three of these rated high on Table 1, which shows the gap analysis of need for services with the usage of services.

Table 2. Comparing need with usage

	% of those needing a service that did not get it in the past 12 months
Hospice Services – Core	94%
Legal Services – Support	94%
Housing Services – Support	93%
Linguistic Services – Support	86%
Health Insurance Assistance – Core	72%
Home Health Care – Core	67%
Emergency Financial Assistance – Support	65%
Substance Abuse Services – Core	61%
Psychosocial Support – Support	45%
Food Bank – Support	43%
Treatment Adherence – Support	40%
Transportation – Support	39%
Oral Health Care – Core	38%
Mental Health – Core	36%
Medical Nutrition Therapy – Core	35%
Medical Case Management – Core	19%
AIDS Drug Assistance – Core	13%
Health Ed./Risk Reduction – Support	10%
Medical Care – Core	3%

As noted in Table 2, there were varied gaps between the need and usage of every eligible Ryan White service. Noticeably, providers were meeting the needs best with Medical Care, Health Education/Risk Reduction, AIDS Drug Assistance, and Medical Case Management. These programs have been the HRSA-mandated focus of the RW Part B program.

There probably was misunderstanding on the part of the clients about some definitions for the less known and less used services. Obvious examples included Hospice Services and Linguistic Services. It is doubtful that Hospice Services were medically indicated for the 103 clients in this sample population that claimed Hospice as a need. Ninety-nine percent of survey respondents indicated that English was the language they were most comfortable speaking yet there is a large gap in meeting the need for Linguistic Services.

Housing Services, Legal Services, Health Insurance Assistance and Emergency Financial Assistance represented the greatest client needs not being met by Ryan White service providers.

Clients claimed ease with obtaining most services that they have tried to access. Oral Health Care, Emergency Financial Assistance, and Medical Transportation were identified as the most difficult to obtain. The reasons stated for these being difficult were service delivery and no access/availability.

Other Services of Importance Identified by Clients

Besides, HIV Medical Care, other services identified as important to the clients in order of most responses: financial assistance (32), housing (22), dental services (22), other health care needs (20), support groups (16), insurance, including Medicaid and Medicare (14), and education (6).

Suggested Changes from Clients

The most commonly stated suggestion for change was for more community awareness, education and testing (25). Other common suggestions were: support groups (16), dental services (15), transportation services (15), and confidentiality (8).

There were also multiple suggestions related to providers (21): these ranged from having more doctors, more clinic hours, better communication with providers, provider choice, less wait time, seeing the same doctor for all health issues, seeing the same doctor each time, and ensuring doctors are knowledgeable HIV specialists.

In conclusion, the majority of clients were satisfied with and thankful for the services they received from the Ryan White Part B providers. Most were self-reported as consistent with their medical care and adherent to their prescribed medication regimen.

Knowledge of Services and Ease of Use

The self-reported adherence to medical treatment was consistent with the findings on client's use of services. Client's needs were most met for: Medical Care, AIDS Drug Assistance, Health Education/Risk Reduction, and Medical Case Management. Clients had greatest knowledge of these services and indicated ease with obtaining them. Knowledge of these services and ease of obtaining services appeared to be contributing factors to reducing unmet need of services and, in this case, adherence to medical treatment.

The less commonly known services seemed to correlate with those services that were less often used and were some of the clients' greatest gaps in service needs. Knowledge of service and ease of access were two variables to consider when reducing service gaps. Client eligibility for specific services, resource limitations, and HRSA priorities may also be factors in these service gaps.

One recommendation suggested by several survey respondents for increasing knowledge of services was to create a service listing by provider. This may increase user knowledge and increase requests for services. The eligibility for services, resources limitations, and HRSA's priorities and resource limitation should also be included.

Recommended Priority Services

As noted in Table 2, all eligible Ryan White services had an identified unmet need. Based on the commonality and consistency of needs identified throughout the survey, needs identified in the gap analysis, and needs stated directly by the client, the following list of services was identified as priorities for reducing the unmet need. HRSA's priorities were also taken into consideration in the development of this list.

- (1) Medical Transportation – Medical Transportation was the only service that was stated by clients to directly interfere with adherence to medical care. Medical Care is one of HRSA's priority services. Transportation was stated as a need by many clients and was considered a difficult service to obtain.
- (2) Oral Health – Oral Health Care is a HRSA priority service. It was consistently mentioned by clients as a need and was difficult to obtain. Although Oral Health Care is relatively well-used service, it can be assumed that the client's dental issues were more involved than the dental services offered.
- (3) Housing Services and Emergency Financial Assistance – With 78% of clients living below 200% of the FPL and 68% of clients not working, housing and emergency financial assistance were widely stated throughout the questionnaire as important needs. Housing was relatively unknown service and was one of the greatest demonstrated gaps. EFA was indicated difficult to obtain.
- (4) Psychosocial Support – Although the gap in Psychosocial Support was not as large as other services, these appeared to be of much value to the clients. Clients clearly indicated a need for support groups and commented on the need for confidentiality and community education. Confidentiality was also a factor in medical care treatment adherence. An assumption could be made that the need for support groups comes from feeling of discrimination and stigma from the community.
- (5) Health Insurance Assistance – Health Insurance Assistance is a HRSA priority service and cost saving to the Ryan White program. Although many clients will not qualify, clients and service providers would benefit if all eligible clients were enrolled.

PCG's report on the Ryan White Part B Consumer Surveys is data in a table format and, thus, a final written report is not available other than the information provided in the above text.

2009 Transgender Survey

In 2006, during a review of SC Ryan White Care programs data by the HIV Planning Council's Needs Assessment Committee, it was noted that eight transgender (TG) persons were receiving Ryan White care and support services in the AID Upstate service area. The entire remainder of the state did not reflect serving as many (8) transgender people. Concerned that this was a data anomaly and not truly reflective of the number of TG persons served in the state, the Committee informally began inquiring as to if and how service providers noted TG clients in their consumer population. As a result of anecdotal reports, the Committee elected to seek a trainer for and begin development of a Transgender 101 course. Upon recommendations of community contacts, a male-to-female transgender person from the upstate was contacted and a successful and informative one-day training was held in late 2006. Following completion of that course, a Capacity Building Assistance request was filed in early 2007 with the CDC for a workshop to be provided by The Transitions Project (UCSF) on HIV Prevention with Transgender Persons. Following that successful skills-building training, the Committee recognized that SC had no needs assessment data on the TG population, and efforts were begun to develop and implement a comprehensive survey of transgender persons. Over the course of 2008, an 18-page survey was developed and pilot tested. In April of 2009, the survey was distributed through social networks of TG persons and via HIV prevention and care contractors. As of July 31, 2009, a total of 17 completed surveys were received. Due to the small number of respondents from the convenience sample, the data were reported to the HPC but no final written was prepared.

2010 Survey of African American Women who have Sex with Men (AAWSM)

In 2010, the HPC documented and reported on the HIV-related knowledge, attitudes, behaviors and beliefs of AAWSM, one of South Carolina's priority populations. This survey was administered to women who: 1) are African American, 2) identify as female, 3) are 18 years or older and 4) live or attend school in South Carolina. Between the months of August and December, 324 surveys were administered to groups of no less than four African American women over the age of 18 that attended and participated in community presentations and other targeted outreach of the STD/HIV Division's prevention contractors and community partners. That report, finalized in March 2011, is available on the HPC website at http://www.schpc.org/images/Final_AAWSM_Survey_Report_3-28-11.pdf.

2011 Survey of African American Men who have Sex with Women (AAMSW)

In 2011, the HPC documented and reported on the HIV-related knowledge, attitudes, behaviors and beliefs of AAMSW, another of South Carolina's priority populations. This survey was administered to men who: 1) are African American, 2) identify as male, 3) are 18 years or older and 4) live or attend school in South Carolina. By design, sexual orientation was not an eligibility determinant. This allowed for a more accurate assessment of all men who may have had sex with women during the last five years, regardless of their self-identified sexual orientation. The survey was designed to be a convenience sample of clients participating in various agency- or clinic-sponsored services or events. A total of 416 surveys were returned. The final report on the survey was presented at the December 13, 2011 meeting of the HPC and is available on the HPC website at http://www.schpc.org/images/AAMSW_survey_report_-_Dec_2011-FINAL.pdf.

2012 Survey of Hispanic/Latino Men and Women

For 2012, the Needs Assessment Committee is working with the Hispanic/Latino Workgroup to assess the HIV-related knowledge, attitudes, behaviors and beliefs of Hispanic/Latino men and women in the eight health department regions across South Carolina. Fourteen implementations of the survey will be conducted, with two in each of six public health regions with higher numbers of Hispanics/Latinos and one each in the other two regions. Agencies and organizations that serve Hispanics/Latinos in these areas were contacted to assist with recruitment of participants and/or to host the surveys. To raise community awareness and dispute common myths, an HIV 101 workshop will be offered immediately after each administration of the survey. When the assessment, data analysis, and final report are completed, the report will be presented at the December HPC meeting and published on the HPC website.

Other data collection efforts in South Carolina are more fully discussed in Chapter 6: Surveillance and Data Collection Initiatives

2. Resource Inventory

This comprehensive resource inventory includes information regarding HIV prevention activities in South Carolina and other education and prevention activities that are likely to contribute to HIV risk reduction. The resource inventory information described in this Chapter helps to describe the ‘met’ prevention needs by geographic area in the state.

South Carolina’s public health system is divided into eight regions representing anywhere from four to ten county health departments. The state office, the STD/HIV Division, is located in the Bureau of Disease Control along with the TB Control Division, Division of Acute Disease Epidemiology, Division of STD/HIV Surveillance, and Immunization Division, all within the Health Services Deputy area of the SC Department of Health and Environmental Control. The STD/HIV Division and Division of STD/HIV Surveillance are physically located on the same floor, enhancing opportunities for data sharing and reporting. The STD/HIV Division also includes and houses Ryan White program staff, increasing communication for linkage to care and joint planning and training efforts.

DHEC Regions



All public health regions offer STD and HIV prevention services including STD screening and treatment, HIV counseling and testing, partner services (formerly know as partner notification and partner counseling and referral services or PCRS), and HIV prevention comprehensive risk counseling and services. Central office staff provides quality assurance, contracts management, training and capacity building, public information/health communication, evaluation, and planning. In 2009, a Resource Inventory of HIV prevention activities was compiled into two sets of tables. The first set of tables, a checklist of services provided by county, provides an at-a-glance look at a spectrum of prevention services. The second set of tables includes prevention contractors and health department providers, the interventions provided, and target populations served.

The format of the Resource Checklist was presented to the HPC during the April 2009 meeting for review and to offer any additions or changes. From that meeting, the checklist was updated and by-county information collected and entered. Services provided in each county were contrasted with services available to county residents but provided outside the county. The revised Resource Checklist for the 2010-2014 Plan was presented and approved at the August 2009 HPC meeting. **The Resource Checklist is currently being updated for 2012 and will be presented at the December HPC meeting.**